

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5908

CERTIFICATE OF DEATH

05917

282

Item 3, Film 182 6-13-55 et

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>St. Marys</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St. Marys</u>	
CITY (If outside corporate limits, write TOWN and give nearest town) <u>Leonardtwn</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write TOWN and give nearest town) <u>St. Marys City</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St. Marys Hospital</u>				STREET ADDRESS <u>Rural</u>		(If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Infant Mary Saint Ann Balta</u>				<u>6 / 5 / 1955</u>			
5. SEX: <u>female</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>		8. DATE OF BIRTH: <u>6/5/55</u>	
9. AGE last birthday: <u>0</u> yrs.		10. MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>1</u> MIN.		9. AGE last birthday: <u>0</u> yrs.		10. MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>1</u> MIN.	
11a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): <u>none</u>		11b. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Paul R. Balta</u>				14. MOTHER'S MAIDEN NAME: <u>Jennie C. Adams</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>----</u>		17. INFORMANT & ADDRESS: <u>Paul R. Balta - St. Marys City, Maryland</u>			
18. MEDICAL CERTIFICATION						Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>759.3 Immediate cause</u> (a) <u>multiple malformations</u>						<u>1 hour</u>	
Antecedent causes (s) (b) <u>DUE TO</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>DUE TO</u>							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 5, 1955</u> to <u>June 5, 1955</u> that I last saw the deceased alive on <u>June 5, 1955</u> , and that death occurred at <u>11 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. W. Patrick MD</u>				ADDRESS <u>Lexington Park, Md.</u>		DATE SIGNED <u>6-5-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6/6/55</u>		<u>St. James</u>		<u>St. Marys City, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>June 6, 1955</u>		<u>Alan D. Sawyer</u>		<u>P.B. Robinson - Leonardtown, Md.</u>			
<u>2055296395</u>							

BUREAU V. S.

JUN 7 1955

RECEIVED

5909

CERTIFICATE OF DEATH

Reg. Dist. No. 281.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>St Marys</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>St Marys</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Leonardtown</i>		<i>14 days</i>		TOWN <i>Park Hall</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<i>78 St Marys Hospital</i>				<i>1</i>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) (Middle) (Last)				OF DEATH:			
<i>Daniel Eugene Dove</i>				<i>June 30 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>Male</i>	<i>Colored</i>	<i>single</i>	<i>June 17-55</i>	<i>74</i> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<i>infant</i>						<i>Maryland St Marys</i>	
13. FATHER'S NAME:				12. CITIZEN OF WHAT COUNTRY?			
<i>Charles Edward Dove</i>				<i>U.S.A.</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
						<i>Mr Louis C Dove Park Hall Md</i>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
761.5 IMMEDIATE CAUSE				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
<i>761.5</i>				<i>Premature birth</i>		<i>6 1/2 months</i>	
ANTECEDENT CAUSE (S)				(B) DUE TO		<i>6 1/2 months</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<i>Placenta previa</i>			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<i>0</i>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>June 17, 1955</i> , to <i>June 30 1955</i> , that I last saw the deceased alive on <i>June 29, 1955</i> , and that death occurred at <i>1:30 P</i> M, from the causes and on the date stated above.							
SIGNATURE <i>PJ Ben</i>				ADDRESS <i>Great Mills Md</i>		DATE SIGNED <i>June 30/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>				<i>7-1-55</i>		<i>Green Fair</i>	
DATE REC'D BY LOCAL REGISTRAR <i>June 30/55</i>				REGISTRAR'S SIGNATURE <i>PJ Ben</i>		24. FUNERAL DIRECTOR'S ADDRESS <i>Hennerville Md</i>	
						<i>Joe C Mattingley Leonardtown Md</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 3 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5910

CERTIFICATE OF DEATH

Reg. Dist. No.

05919

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY ST. MARY'S		MARYLAND		STATE MARYLAND		COUNTY ST. MARY'S	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
RURAL PARK HALL		LIFE		RURAL PARK HALL			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
THEODORE LYDERMAN DRURY				JUNE 13, 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
MALE	WHITE	MARRIED	JUNE 24, 1887	67 yrs.	11 Months	20 Days	0 Hours 0 Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life)			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
WATERMAN & BAR TENDER			BAR ROOM		MARYLAND		U.S.A.
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
GEORGE DRURY				GEORGIANA RALEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:		
NO			217-12-3321		CATHERINE MABEL DRURY PARK HALL, MD.		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Coronary occlusion							2-3 min.
ANTECEDENT CAUSE (B) Coronary arterio sclerosis							3 years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct , 19 54 , to 6-13 , 19 55 , that I last saw the deceased alive on 3-20 , 19 55 , and that death occurred at 12:05 PM from the causes and on the date stated above.							
SIGNATURE [Signature]				ADDRESS 2000 Hill, Md.		DATE SIGNED 6-14-55	
23. BURIAL CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		6/16/55		ST MICHAEL'S		RIDGE, MD.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
6/15/55		[Signature]		Jos. C. Mattingley		Leonardtown, Md.	

BUREAU V. S.

JUN 17 1955

RECEIVED

5911

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY ST MARY'S		MARYLAND		STATE MARYLAND COUNTY ST MARY'S			
CITY (If outside corporate limits, write RURAL OR and give nearest town) LEONARDTOWN		LENGTH OF STAY (in this place) 3 MONTHS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LEONARDTOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS ST MARY'S HOSPITAL				STREET ADDRESS (If rural give location) 1			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
MARYLIN MARIE HILL				JUNE 14, 1955			
5. SEX: FEMALE	6. COLOR OR RACE: BLACK	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH: MARCH 14, 1955	9. AGE last birthday: 3 yrs.	IF UNDER 1 YEAR: Months	IF UNDER 24 HRS.: Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: FRANCIS RUSSELL				14. MOTHER'S MAIDEN NAME: ANN MARIE HILL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS: ANN MARIE HILL CHAPTICO, MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Hydrocephalus						2 mos.	
ANTECEDENT CAUSE (S) Congenital anomaly, brain						3 mos.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 14 June, 1955 , to 14 June, 1955 , that I last saw the deceased alive on 13 June, 1955 , and that death occurred at 8:00 M, from the causes and on the date stated above.							
SIGNATURE Joseph E. Hill m.d.				ADDRESS Leonardtown Md		DATE SIGNED 6/10/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 6/15/55		NAME OF CEMETERY OR CREMATORY SACRED HEART		LOCATION (City, town, or county) (State) BUSHWOOD, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR 6/15/55		REGISTRAR'S SIGNATURE Alan D. Hance		24. FUNERAL DIRECTOR JOS. C. MATTINGLEY		ADDRESS LEONARDTOWN, MD.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 17 1955

RECEIVED

5912

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Saint Mary's		MARYLAND		STATE Maryland		COUNTY St. Mary's	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Abell		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Abell			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural				STREET ADDRESS (If rural give location) Rural			
3. NAME OF DECEASED: (First) (Middle) (Last) Agnes Estell MATTINGLY				4. DATE (Month) (Day) (Year) OF DEATH: June 18, 1955			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: 1 / 25 / 1880	9. AGE last birthday 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY: Domestic		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James H. BAILEY				14. MOTHER'S MAIDEN NAME: Julia RUSSELL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) *****			16. SOCIAL SECURITY NO. *****		17. INFORMANT & ADDRESS: Robert A. MATTINGLY :: Abell, Maryland		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Carcinoma of pancreas							8 mos
ANTECEDENT CAUSE (S) with metastases							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 1 Nov 54		19B. MAJOR FINDINGS OF OPERATION: Pancreatic without malignant changes in biopsy					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 18, 1954 to June 18, 1955 , that I last saw the deceased alive on June 17, 1955 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.							
SIGNATURE Robert A. Mattingly		ADDRESS Neelandsville		DATE SIGNED 6/15/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 21, 1955		NAME OF CEMETERY OR CREMATORY Sacred Heart Cem.		LOCATION (City, town, or county) (State) Bushwood, Maryland.	
DATE REC'D BY LOCAL REGISTRAR 6/20/1955		REGISTRAR'S SIGNATURE Gladys L. Lawrence		24. FUNERAL DIRECTOR P. B. Robinson :: Leonardtown, Md.		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 21 1955

BUREAU V. S.

5913

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY ST MARY'S		MARYLAND		STATE MARYLAND		COUNTY ST. MARY'S	
CITY (If outside corporate limits, write RURAL OR and give nearest town) HERMANVILLE		LENGTH OF STAY (in this place) 9 YRS.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL HERMANVILLE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00				STREET ADDRESS (If rural give location) 1			
3. NAME OF DECEASED: (First) (Middle) (Last) LILLIE MAY McDONALD				4. DATE (Month) (Day) (Year) OF DEATH: JUNE 15, 1955			
5. SEX: FEMALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH: 2/16/1871	9. AGE last birthday 84 yrs.	IF UNDER 1 YEAR Months 3 Days 30	IF UNDER 24 HRS. Hours Min. 	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE			10B. KIND OF BUSINESS OR INDUSTRY: HOME		11. BIRTHPLACE (State or foreign country): PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: MORGAN JINKINS				14. MOTHER'S MAIDEN NAME: UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) NONE		17. INFORMANT & ADDRESS: MORGAN McDONALD HERMANVILLE, MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Coronary occlusion						immediate	
ANTECEDENT CAUSE (S) (B) Arteriosclerosis (general)						10 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 15, 1955 , to June 15, 1955 , that I last saw the deceased alive on June 15, 1955 , and that death occurred at 8 P M, from the causes and on the date stated above.							
SIGNATURE [Signature]		M. D. [Signature]		ADDRESS [Signature]		DATE SIGNED 6/16/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 6/18/55		NAME OF CEMETERY OR CREMATORY STEWARTSTOWN, PENNA.		LOCATION (City, town, or county) (State) LEONARDTOWN, MD.	
DATE REC'D BY LOCAL REGISTRAR 6/16/55		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR ADDRESS JOS. C. MATTINGLEY LEONARDTOWN, MD.			

MARGIN RESERVED FOR BINDING

RECEIVED

JUN 20 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05923

5914

CERTIFICATE OF DEATH

Reg. Dist. No. 281.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY St. Mary's		MARYLAND		STATE Pennsylvania		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Patuxent River		LENGTH OF STAY (in this place) -		CITY (If outside corporate limits, write RURAL and give nearest town) OR Glenmoore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Station Hospital, U. S. Naval Air Station				STREET ADDRESS (If rural give location) Main Street			
3. NAME OF DECEASED: (First) (Middle) (Last) James Grier MILLER				4. DATE (Month) (Day) (Year) OF DEATH: June 12 19 55			
5. SEX: Male	6. COLOR OR RACE: Caucasian	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 19 January 1936	9. AGE last birthday 19 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps		10B. KIND OF BUSINESS OR INDUSTRY: USMC		11. BIRTHPLACE (State or foreign country): Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: James Grier MILLER				14. MOTHER'S MAIDEN NAME: Pearl (n) BAUM			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) 4-21-54/6-12-55 ---		17. INFORMANT & ADDRESS: Records			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Wound, Missile, Gun Shot, Right Eye						15 min.	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OR INJURY street, office bldg., etc.) Main Gate		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? Patuxent River, St. Mary's, Md.			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: June 11, 1955 11:55		21E. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR? Accidental discharge of gun			
2. I hereby certify that I attended the deceased from June 11, 1955 , to June 12, 19 55 that I last saw the deceased alive on June 12, 1955 , and that death occurred at 12:10 A.M. , from the causes and on the date stated above.							
SIGNATURE Jeno E. Szakacs		ADDRESS M. D. Station Hosp. NAS PAX RIV MD		DATE SIGNED 6-13-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Transportation		DATE THEREOF 6-14-55		NAME OF CEMETERY OR CREMATORY McLean Funeral Home		LOCATION (City, town, or county) (State) Coatesville, Pennsylvania	
DATE REC'D BY LOCAL REGISTRAR 6/14/1955		REGISTRAR'S SIGNATURE P. B. Robinson		24. FUNERAL DIRECTOR P. B. Robinson		ADDRESS Leonardtown, Md.	

RECEIVED

JUN 20 1955

BUREAU V. S.

Item 8, Film G183 6-28-55 et

5915

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Saint Mary's		MARYLAND		STATE Maryland		COUNTY St. Mary's	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Mechanicsville				X TOWN Mechanicsville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 Rural				Rural			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) William		(Middle) Brown		(Last) SUITE		DEATH: June 17, 1955	
(Type or Print)							
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	single	September, 1878 ??	77 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
Tenant			Farming		Maryland		U.S.A.
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Norris SUITE				Rosie WILLIAMS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
No (If Yes, give war or dates of service) *****				*****		Joseph SUITE:: Mechanicsville, Md.	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) 420.1 Coronary thrombosis						2 days	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (B)							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerotic cardiovascular dis.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
0							
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 16, 1955 , to June 17, 1955 , that I last saw the deceased alive on June 16, 1955 , and that death occurred at 12:30 M, from the causes and on the date stated above.							
SIGNATURE John E. Gaylor		M. D. Mechanicsville		ADDRESS Mechanicsville		DATE SIGNED 6/17/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		6/20/55		St. Joseph's Cemetery		Morganza, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
6/20/55		Glenn D. House		P. B. Robinson :: Leonardtown, Md.			

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VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 21 1955

RECEIVED

5916

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY St. Mary's		MARYLAND		STATE Maryland		COUNTY St. Mary's	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Avenue			
X TOWN Leonardtwn				STREET ADDRESS (If rural give location) 1			
HOSPITAL OR INSTITUTION OR STREET ADDRESS St. Mary's Hospital							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
Daisy Dell Wible				June 4, 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	White	Married	Aug. 30, 1878	76 yrs.	9 Months	5 Days	5 Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Housewife				Home		Virginia	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Howard Morders				Mary Ramey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
NO				NONE		Mrs Joe Bailey Avenue, Maryland	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Heart Failure						3 weeks.	
ANTECEDENT CAUSE (S) DUE TO (B) Chronic Myocarditis - Myocardial Degeneration						Several years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Uremia						2 weeks.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 29 1954 to June 4, 1955 that I last saw the deceased alive on June 4, 1955 , and that death occurred at 9:40 PM , from the causes and on the date stated above.							
SIGNATURE Robert T. Fuchs				ADDRESS Leonardtwn, Md.		DATE SIGNED 6/7/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		6/7/55		All Saints		Oakley, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
6/9/55		Glean D. House		Jos. C. Mattingley		Leonardtwn, Md.	

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BUREAU V. S.

JUN 8 1955

RECEIVED

5917

CERTIFICATE OF DEATH

Reg. Dist. No. 281.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY St. Mary's		MARYLAND		STATE Maryland		COUNTY Calvert	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Patuxent River		LENGTH OF STAY (in this place) --		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Solomons Island			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Station Hospital, U. S. Naval Air Station				STREET ADDRESS (If rural give location) General Delivery			
3. NAME OF DECEASED: (Type or Print)		(First) Gene		(Middle) Walter		(Last) YOUNG	
4. DATE OF DEATH:		Month June		Day 9		Year 19 55	
5. SEX: Male	6. COLOR OR RACE: Caucasian	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 9 June 1955		9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME: Walter Ire YOUNG				14. MOTHER'S MAIDEN NAME: Rosalie Caroline BAKER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: Records			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Prematurity						2 hrs 56 min	
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9 June , 19 55 , to 9 June , 19 55 , that I last saw the deceased alive on 9 June , 19 55 , and that death occurred at 0800 A. , from the causes and on the date stated above.							
SIGNATURE S. GASSARA, LCDR MC USNR		ADDRESS Station Hosp. NAS PAX RIV MD.		DATE SIGNED 9 June 1955		M. D.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		6-10-55		Cheney Cem. California, Mo.			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
6-9-55		J. J. Bean, M.D.		U. S. Navy - Patuxent River, Md.			
2065191990 Local Registrar							

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DECLARATION OF INTENT

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JUN 13 1955

BUREAU V. S.

JUN 13 1955

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